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May 31, 1982

To: Local Board of Health

Subject: The Housing Gap: Deficiencies In Appropriate Housing For Ex-Psychiatric Patients

Origin: Medical Officer of Health, May 31, 1982 (c37hlth82059:37)

Comments:

I am pleased to forward for your approval this report on "The Housing Gap: Deficiencies In Appropriate Housing For Ex-Psychiatric Patients". The Report, prepared by consultants Liss Jeffrey and Carol Montagnes, was funded by this Department, but in fact is a healthy collaborative effort between us and the Supportive Housing Coalition. Gerald Caplan of the Health Advocacy Unit was responsible for the Department's participation, while Reg Foster of the Canadian Mental Health Association represented the Coalition.

What this Report does is to underline in no uncertain terms the magnitude of the housing crisis faced by ex-psychiatric patients in this City. Documenting in many instances the severity of the problem with facts and figures not previously assembled, the Report makes clear that words like "crisis" and "emergency" are in no way excessive. On the contrary, failure by the Provincial government to take immediate action on the recommendations contained here will constitute little less than an abdication of legitimate, urgent responsibility.

For that reason, I recommend the Local Board of Health adopt these recommendations, including recommendation 11 which explicitly calls on the Department to play an advocacy role with the Provincial government.

Medical Officer of Health

GLC:ks
Attach.

THE HOUSING GAP: DEFICIENCIES IN APPROPRIATE HOUSING FOR EX-PSYCHIATRIC PATIENTS

JOINT STUDY FOR THE
CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH
AND
THE SUPPORTIVE HOUSING COALITION

STUDY DESIGNED AND CONDUCTED BY:

Liss Jeffrey, A.B.(Harvard) - Independent Consultant
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MAY, 1982

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Queen Street Mental Health Centre, particularly staff of the Assessment and Referral Unit.

Administrators and field workers of the Operational Support Branch, Ontario Ministry of Community and Social Services.

Various staff members of the psychiatric units of the general hospitals that were surveyed.

Special thanks to all hostel staff who took time to complete the questionnaires, and discuss their problems.

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The Supportive Housing Coalition wishes to especially acknowledge the support and help of the City of Toronto Local Board of Health, Dr. Alexander Macpherson, Gerry Caplan, Dr. Edgar Wong, Connie Kirkland, Norma Drummond, and Kathie Swain.

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The project benefited from the guidance of the management/resource group consisting of:

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population. Nevertheless from these diverse elements emerges a composite picture.

At the conclusion of the report a variety of recommendations are offered. Many of these have been made elsewhere but to date have not been implemented.

METHODOLOGY

A variety of research methods were employed to collect information from psychiatric institutions, psychiatric units of general hospitals, house-finding services, welfare agencies, hostels, community programs, and alternative housing operations.

* In order to obtain information regarding patients discharged from psychiatric hospitals, contact was made with a provincial psychiatric hospital, Queen Street Mental Health Centre, and with a psychiatric research institute, the Clarke Institute of Psychiatry.

  At Queen Street Mental Health Centre, access was gained to data collected on the patients discharged over a two-week period. During the first week, individual questionnaires were completed for all patients being discharged from two units of the hospital. During the second week, questionnaires were completed for all patients being discharged from the remaining two units of the hospital.

  At the Clarke Institute of Psychiatry a "patient questionnaire" (see Appendix I) was completed by social work discharge staff for each patient being considered for discharge from the facility during a one-week period. In addition, a "general survey" questionnaire (see Appendix II) was completed by each social worker involved in discharge planning.

  Interviews were also carried out at the two psychiatric hospitals with staff members directly involved with admissions to the facility.

* In order to obtain data from the psychiatric units of general hospitals, three general hospitals were contacted. These hospitals were selected primarily for their varied geographic locations: one was a downtown hospital, one was located in the east end of the City and one was situated in a northwest suburban area. Interviews were conducted with staff directly involved in discharge planning and in admissions.

* Another method employed to determine the extent of the problem was to contact three services directly involved in providing

INTRODUCTION

In the past twenty years, the mental health care system in Ontario has undergone dramatic change. The number of beds in the large provincial psychiatric hospitals has been slashed to a quarter of what it was in the early 1960's, and the average length of stay has decreased significantly.

The forces behind this change were the powerful new psychotropic drugs, which stabilized symptoms more quickly than had previous methods, and the therapeutic theory of normalization with its vision of the former psychiatric patients living in the community, supported by a network of services attuned to their needs, rather than living out their lives on the back wards of large institutions. In the same period, many studies confirmed the negative effects of long term institutionalization.

The technique designed to bring this population into the community was termed "deinstitutionalization". The idea was systematically to shift resources out of the hospitals into the community, and create a wide range of programs to support ex-patients in their reintegration to normal living.

Unfortunately, the government's thrust to decentralize did not take this direction. The resources that were shifted went primarily to create psychiatric units in general hospitals and homes for special care, often a form of mini-institution. Community programs were neglected.

Three recent reports have documented deficiencies in the community support network (1,2,3). These reports showed that patients discharged from hospitals lack sufficient support in the areas of housing, income maintenance, and social and recreational activities. Last September the Supportive Housing Coalition stated that "Metro Toronto is now in the midst of a severe housing crisis for former psychiatric patients" (4). Our report focusses on deficiencies in appropriate housing for ex-psychiatric patients: what we have called the housing gap.

The purpose of this study is to examine the difficulties ex-psychiatric patients have in obtaining appropriate housing, the degree of those difficulties, the reasons for them, and the implications of this situation.

The study's findings represent a "snapshot" of the current state of services which intersect with the ex-psychiatric population.

Delving as it does into hospital discharge practices, accommodation-locating services, through community support and housing programs, and into income maintenance and the hostel system, the methodology of the study is in itself testimony to the disjointed nature of programs serving the ex-psychiatric

assistance in locating housing for discharged psychiatric patients. One of these services, the Assessment and Referral Unit, is located at Queen Street Mental Health Centre. Records kept by the Unit itself were consulted in our research.

WoodGreen Community Centre has operated a room-finding service for ex-psychiatric patients and others since February of this year. Through interviews and examination of a progress report from the Centre's psychiatric aftercare worker, a sense of the need for appropriate housing was obtained.

The only other known service directly involved in helping ex-psychiatric patients locate housing is the "Open Door Rooms Registry". A staff member contacted at the "Open Door Rooms Registry" was unable to provide statistical data, but nevertheless did state that the service was experiencing problems finding affordable housing for all their clients, including ex-psychiatric patients.

* Many ex-psychiatric patients are known to depend on welfare assistance as their sole source of income. Therefore, to gather data concerning ex-psychiatric patients in receipt of general welfare assistance, questionnaires were given to each of the general welfare assistance offices in the Metropolitan Toronto area, with the request that five welfare workers from each office complete the forms. The questionnaires (see Appendix III) pertained to the workers' permanent caseload.

Interviews were held, in person and by telephone, with family benefits administrators, and field workers at the local family benefits office serving that portion of the City which includes the Parkdale area where a concentration of ex-psychiatric patients reside.

* A survey was designed to determine the extent of the problem at the 18 hostels in Metropolitan Toronto that provide emergency or short-term accommodation. Due to the transience of the hostel population and the lack of any complete data on the number of ex-psychiatric patients using the hostel service, it was decided to obtain a comprehensive cross-section of the situation at all 18 hostels on one night: Tuesday, April 6th, 1982. A questionnaire was developed that could be administered easily by the busy intake staff. After receiving the cooperation of all the hostels, criteria were established for determining which residents had a psychiatric history or a probable psychiatric history (see Appendix IV). In some cases, information regarding psychiatric history was contained in records kept on the individual residents; in other cases hostel staff had personal knowledge based on previous contact. In some cases, where records were not kept, residents were questioned directly on the night of the survey.

The question concerning the probable psychiatric history tapped the direct experience of intake staff who, in many cases, regularly make such observations in order to determine potential problems for the hostel.

The results were supplemented by extensive interviews with hostel staff concerning difficulties they had experienced with housing the psychiatric population.

* To obtain a wider perspective of the problem, five community services offering programs to the ex-psychiatric population were contacted. These were selected because they serve a large ex-psychiatric population, or have programs suited to a transient population. Through interviews with staff members an estimate was obtained of how many of the people using the programs were currently having housing problems. In some cases staff were able to comment on the contribution of housing problems to the deterioration of the person's condition.

  One community centre had already compiled data on the housing problems of the psychiatric population. This information was incorporated into our findings.

  One of the drop-in centres arranged for interviews with selected ex-patients who were encountering housing problems. This revealing information was used and is presented here primarily as background and a guide to problem areas.

* Data was gathered from the 10 alternative community housing operations in Metro. These facilities provide 133 beds for the ex-psychiatric population in a range of supportive housing environments. A senior representative of each operation was contacted in order to determine the demand for such housing as measured by the number of inquiries received, the number of placements made, and the length of waiting lists.

SYNOPSIS OF FINDINGS

The findings are presented in the form of answers to eight key questions. These questions reflect critical problem areas for ex-psychiatric patients seeking housing in Metropolitan Toronto. The first five questions examine the difficulties in obtaining appropriate housing; questions six and seven ask why these difficulties occur; and question eight probes the impact of housing problems on hospital readmissions. The complete findings are contained in the body of the Report.

1. DOES THE LACK OF SUPPORTIVE ACCOMMODATION DELAY THE DISCHARGE OF PSYCHIATRIC PATIENTS FROM PSYCHIATRIC FACILITIES?

   Yes. There is a consensus among hospital staff involved in discharge planning that problems in securing supportive accommodation in the community result in delays in patient discharge. At the Clarke Institute of Psychiatry, 31% of the discharges during the survey period had been delayed due to placement problems, and at Queen Street Mental Health Centre, 26% of the discharges had been delayed because of difficulties in finding appropriate housing in the community.

2. WHAT PERCENTAGE OF PSYCHIATRIC PATIENTS BEING DISCHARGED REQUIRE A HOUSING PLACEMENT WITH SOME LEVEL OF SUPPORT?

   More than half, 53%, of the patients discharged from the Queen Street Mental Health Centre during the survey time period were assessed as requiring 24-hour supervision.

   At the Clarke Institute of Psychiatry, 62% of the patients considered for discharge during our survey were judged to be in need of support or supervision on a 24-hour or daily basis.

3. WHAT IS THE CURRENT EXPERIENCE OF SPECIALIZED SERVICES SET UP TO FIND HOUSING FOR EX-PSYCHIATRIC PATIENTS?

   In the first three months of its operation, the Assessment and Referral Unit at Queen Street Mental Health Centre completed the processing of 62 cases. Of these 62 cases, 50% were assessed as requiring a housing placement with 24-hour supervision or support. Eleven patients with this requirement either remained in Queen Street Mental Health Centre because no housing placement could be found, or were placed unsuccessfully and returned to the Centre.

   In the first two months of operation at the WoodGreen Community Centre, 25% of the 123 requests for help to the house-finder service came from ex-psychiatric patients. One worker's caseload included nine ex-psychiatric patients who had been looking for housing for several weeks, one of whom had been looking for over a month.

4. IN WHAT SORT OF HOUSING ARE EX-PSYCHIATRIC PATIENTS CURRENTLY RESIDING?

   Information from Queen Street Mental Health Centre showed that although 18% of the discharged patients were going to live with family, 11% were going to live on their own in a rented room, 7% were going to live in a boarding house, and 7% did not know where they would go. No housing information was available for 32% of the ex-patients.

At the Clarke Institute, 28% of the discharged patients planned to live with family, but 24% intended to stay on their own in a rented room.

Data from general welfare assistance staff indicated that 42% of their "psychiatric" clients were living alone in a rented room, while 29% were in a boarding house situation.

5. HOW MANY EX-PSYCHIATRIC PATIENTS ARE CURRENTLY HOMELESS OR WITHOUT ADEQUATE HOUSING?

The survey of all the hostels in Metropolitan Toronto found 249 people (17% of total adults) with a known or probable psychiatric history staying in the hostels on Tuesday, April 6th, 1982. In addition, a subgroup of the psychiatric population that is denied admission to the hostels was identified. Sixty-eight percent of the 366 names on the "barred lists" and 67% of the 256 names on the "caution alerts" appear on these lists for psychiatric reasons.

The five community programs reported that from 28% to 60% of their clients were experiencing problems finding suitable accommodation.

6. DOES THE LEVEL OF INCOME AVAILABLE TO EX-PSYCHIATRIC PATIENTS AFFECT THEIR ABILITY TO FIND SUITABLE HOUSING?

Yes. Well over half the patients discharged at the two psychiatric facilities surveyed during the research relied on welfare as their source of income. For this group, the ability to find suitable housing is severely restricted. The cheapest rented room costs more than half the monthly allowance, and the least expensive boarding house consumes almost the full amount.

7. HOW HEAVY IS THE DEMAND FOR THE AVAILABLE SUPPORTIVE HOUSING?

There is increased demand for the 133 beds offered by the alternative community housing operations. Referrals and inquiries are generally up, and those operations which keep waiting lists currently report 59 people awaiting accommodation. Residents are staying in these programs longer, and the time spent on waiting lists is increasing.

8. DO HOUSING PROBLEMS CONTRIBUTE TO READMISSION TO A PSYCHIATRIC FACILITY?

It was difficult to arrive at a definitive measure of the influence of the housing problem on actual admission. However, there was consensus among hospital staff interviewed that housing problems did play a part in causing ex-psychiatric patients to <u>seek</u> readmission. As well, the

operators of the community programs repeatedly stressed the relationship between difficulties in finding adequate housing and readmission to hospital.

FINDINGS

Question #1

DOES THE LACK OF SUPPORTIVE ACCOMMODATION DELAY THE DISCHARGE OF PSYCHIATRIC PATIENTS FROM PSYCHIATRIC FACILITIES?

In order to determine whether delays in discharge were occurring, two psychiatric institutions and three general hospitals with psychiatric wards were contacted. Information was gathered from staff directly involved in patient discharge planning, through questionnaires and interviews.

In 44% (32) of the 73 discharges during the two-week survey time period at Queen Street Mental Health Centre, the patient or therapist stated there had been difficulties in finding accommodation. 26% (19) of the 73 discharges had actually been delayed due to problems in securing appropriate housing in the community.

At the Clarke Institute of Psychiatry, 31% (9) of the 29 discharges during the one-week survey time period had been delayed due to placement problems.

Many staff members complained about the general lack of housing providing any type of support and about the long waiting lists at the limited number of supportive housing operations that do exist. In some cases, rather than discharge a recently stabilized psychiatric patient into a temporary housing situation which the therapist felt might lead to the patient's deterioration, the therapist chose to keep the patient in hospital until a bed was available in an appropriate setting. In other cases, because no options were available, patients were discharged to inappropriate accommodation, or even situations the therapist considered destructive. The consequences to the patient of being discharged to such an environment are discussed in a later section, which considers factors contributing to readmission.

At the three general hospitals contacted during the course of the research, the response to the question of discharge delays varied. "A big problem" was how one of the staff members directly involved in discharge planning at a downtown hospital characterized the situation. She stated that over 20% of the patients presently in one psychiatric ward had had their discharge delayed while awaiting placement.

A therapist at an east end hospital described the problem as "a constant hassle" and "a chronic problem", especially with regard to their crisis unit which is supposed to have a maximum stay of 72 hours. Frequently patients remained beyond the 72-hour period waiting for housing to be secured.

The situation appeared somewhat different in the suburban hospital contacted. There the discharge planners interviewed agreed that it was "not unheard of to keep someone" beyond the time they were medically ready for discharge because of difficulties in finding a suitable placement. However, it was suggested that this suburban hospital serves a different client than the downtown hospitals, in that an estimated 80% of this suburban hospital's psychiatric patients live with their family or have families who are to some degree supportive.

All the psychiatric institutions contacted were asked to describe what type of patient posed the greatest difficulty in arranging a housing placement. This question elicited a wide range of responses, from "anyone who needs supervision at any level" to specific groups, such as people in their late teens, middle-aged women, substance abusers and those with the double stigma of a criminal as well as a psychiatric history. The most frequently noted group, however, was the poorly motivated, marginally functioning chronic patient, unable to live independently in the community.

Question #2

WHAT PERCENTAGE OF PSYCHIATRIC PATIENTS BEING DISCHARGED REQUIRE A HOUSING PLACEMENT WITH SOME LEVEL OF SUPPORT?

Of the 73 discharges at Queen Street Mental Health Centre in the two-week survey period, 38% (28) were assessed by therapists as being in need of an intermediate level of care. Intermediate care is defined by Queen Street Mental Health Centre as "that level of care required by persons who have been discharged from or referred from a psychiatric facility, and who no longer require in-patient hospitalization, but require housing and care under 24 hour supervision in a facility approved by the Ministry, due to their clinically determined disability".

A further 15% (11) of the patients discharged were deemed to require more than intermediate care. These were largely psychogeriatric patients.

At the Clarke Institute, where 29 patients were considered for discharge during the one-week survey period, 62% (18) were judged in need of 24-hour or daily supervision or support. It is noted that none of these individuals assessed as needing such high support accommodation were psychogeriatric patients.

At the general hospitals surveyed, there was recognition of the need in the community for supportive housing, but it was difficult to determine the extent of the perceived need since no records had been kept for this purpose. However, Toronto East General Hospital is presently conducting a survey of 16 Metropolitan Toronto general hospitals plus the Clarke Institute of Psychiatry, to estimate the need for high support housing (24-hour staffing). In the survey, the hospitals were asked to estimate the number of individuals served by their department or agency within the last twelve-month period for whom a high support halfway house program would be of benefit. To date information is available for 8 of the 16 hospitals, and the estimates range from a low of 2 to a high of 211 individuals per hospital. Considering only these 8 of the 16 hospitals for which information is available at this point, the total number of people suggested is already 590.

In addition, there is yet another study underway focussing on supportive housing in the community. The "Inter-hospital Committee of North York" surveyed the housing needs of discharged psychiatric patients at 6 northern Toronto hospitals and is presently preparing a report which is expected to be completed in May 1982.

The fact that these studies are being carried out indicates the amount of concern felt by mental health service providers regarding the problems of supportive housing. Another illustration of the extent of this concern has been the willingness and cooperation of the individuals and organizations contacted in our own research to give considerable time and effort to describe the needs for supportive housing from their point of view.

Question #3

WHAT IS THE CURRENT EXPERIENCE OF SPECIALIZED SERVICES SET UP TO FIND HOUSING FOR EX-PSYCHIATRIC PATIENTS?

An Assessment and Referral Unit has been established at the Queen Street Mental Health Centre to offer the following services: (1) a housing registry; (2) help in finding a place to live; and (3) arrangement of an intermediate level of care placements. Referrals are accepted from psychiatric facilities and community agencies. Between the period of mid-December, 1981 (when the Unit started) and mid-March 1982, 221 referrals had been received, with approximately half the calls coming from within the Queen Street Mental Health Centre.

"Needs assessment" forms are used by staff in making the decision as to whether or not the referred patient satisfies the criteria and is eligible for intermediate level care. From the time the Unit began operating, until mid-March, 1982, "needs assessment"

forms were filled out for 80 individuals, and, of these, 62 cases were completed, or "closed". 50% (31) of these "closed" cases were assessed as needing less than intermediate care (as previously defined), 19% (12) individuals required intermediate care, and 31% (19) required care above this level.

Eleven patients requiring intermediate care or higher either remained in Queen Street Mental Health Centre because no housing placement could be found, or were placed unsucessfully and returned to the Centre.

Last summer a large community centre, WoodGreen, which offers programs to the psychiatric population, set up a room-finding assistance program in cooperation with Nellie's, a hostel for women. The project clearly demonstrated a need for this service, and it has been operating with three full-time staff members since February, 1982. Requests for help came in from 123 people in the first two months of operation, 25% of whom have a psychiatric history. One project worker described the current difficulty obtaining suitable accommodation for ex-patients as "worse than desperate". Her caseload includes 9 ex-psychiatric patients who have been looking for appropriate housing for weeks, in one case, over a month.

Based on the experience so far, the Assistant Director of Community Programs identified two key problem areas: the need for practical and emotional support during the room-finding process, and welfare advocacy. She reported that all clients of the housing service "run into the catch-22 situation which is no money, no place to live; no place, no money from welfare".

The Community Centre spent months successfully negotiating an arrangement with the local welfare office which it feels is critical to the success of the room-finding service. Since early March, designated staff from the Community Centre have been authorized to call the welfare office on a client's behalf to confirm that the client has found accommodation and needs emergency assistance immediately to pay the rent deposit. Welfare staff then prepares the cheque ($50 per person) which the client picks up the same day after producing a letter from the Community Centre verifying the arrangement. In turn, the Community Centre has agreed to limit their requests for emergency assistance to one person or family per day. So far the Centre has made use of this agreement every single day.

Question #4

IN WHAT SORT OF HOUSING ARE EX-PSYCHIATRIC PATIENTS CURRENTLY RESIDING?

Information received from the two-week survey at Queen Street Mental Health Centre showed that for the 73 patients discharged: 18% (13) were going to live with family, 11% (8) had their own rented room, 7% (5) were going to a boarding house, and 7% (5) did not know where they would go. An additional 4% (3) had their own or shared apartment, and 3% (2) intended to stay with friends. 4% (3) went to a nursing home, and 4% (3) to a retirement home. 3% (2) had their own home or condominium. Two individuals were discharged to a general hospital, and one each went to another psychiatric institute, a home for special care, an approved home, or jail. Housing destinations were not available for 23 people.

This information is presented in Table 1 where it is compared with the results from the Clarke Institute.

52% of the patients discharged from Queen Street Mental Health Centre were not returning to their previous address, but were seeking new accommodation.

The data obtained from the one-week survey of the patients being considered for discharge from the Clarke Institute of Psychiatry revealed a slightly different picture. A larger percentage of patients than at Queen Street Mental Health Centre intended to live with family, 28% (8); and a considerably larger percentage were going to live on their own in a rented room, 24% (7). Also, 17% (5) of the patients were discharged to a group home, whereas none of the Queen Street Mental Health Centre patients was going to a group home. 10% (3) were returning to their own house or condominium, and 7% (2) had their own apartment. Only one person was going to a boarding house and one was being returned to an out-of-town general hospital. No information was available for two people.

TABLE 1

INTENDED ACCOMMODATION OF DISCHARGED PSYCHIATRIC PATIENTS

ACCOMMODATION	DISCHARGED FROM QUEEN STREET MENTAL HEALTH CENTRE #	%	DISCHARGED FROM CLARKE INSTITUTE OF PSYCHIATRY #	%
With Family	13	18%	8	28%
Own Rented Room	8	11%	7	24%
Boarding House	5	7%	1	3%
"Streets"	5	7%		
Own/Shared Apartment	3	4%	2	7%
Own House/Condominium	2	3%	3	10%
With Friends	2	3%		
Group Home			5	17%
Retirement Home	3	4%		
Nursing Home	3	4%		
General Hospital	2	3%	1	3%
Home for Special Care	1	1%		
Approved Home	1	1%		
Psychiatric Institute	1	1%		
Jail	1	1%		
No Information	23	32%	2	7%
Total Number of Patients	73		29	*

* Percentages do not total 100%, due to rounding.

Total Annual Discharges, QSMHC, April 1, 1980 - March 31, 1981: 3761

Total Annual In-patient Discharges, Clarke Institute, April 1, 1981 - March 31, 1982: 1241.

59% of the 29 psychiatric patients discharged from the Clarke Institute were returning to the address they had on admission. For the 41% (12) who were not returning to their previous address, a list of the reasons why not on the questionnaire gives an illuminating glimpse into their living situation prior to hospital admission: "evicted", "not welcome back", "separated from husband", "parents won't allow him to return home", "room no longer available", "group home placement breakdown", "judged unsuitable to live with family", "needs supervision", and, simply, "unsuitable".

Information was also available on these patients discharged from the Clarke Institute which showed the intended accommodation plus assessed level of supervision or support for each patient. 18 of the 29 discharged patients were judged by their social worker to require either 24-hour supervision/support or daily full-time supervision/support. Of these 18, 28% (5) were going out to live on their own in a rented room, 28% (5) intended to live with family, and 22% (4) were going to a group home. One of these people requiring a high level of support was going to a boarding house, and one was being returned to a general hospital out-of-town for further treatment. No housing information was available for two people.

To obtain information on the housing situation of ex-psychiatric patients already living in the community, questionnaires were completed by field workers at eight of the ten general welfare assistance offices in the Metropolitan Toronto area. These questionnaires reported on an active caseload of 2861 general welfare assistance clients. Of these clients, 400 or 14% were considered by their regular welfare field worker to have current or past mental/psychiatric problems. Housing information for 393 of this group indicated the following: 42% (164) were living in a rented room, 29% (113) were in a boarding house, 9% (34) were residing in financially-assisted housing (OHC, Cityhome), 8% (30) lived in an apartment and 8% (30) with their family. 2% (8) were in group homes, and 2% (8) were in approved homes. Three people owned a house or condominium, and one rented a house. Two people were living "on the street" with no fixed address. No housing information was given for seven persons.

The southwestern area of the City had the highest concentration of "psychiatric" clients per caseload, as might have been expected, 19%, and the highest use of boarding homes. 58% of the "psychiatric" clients living in this area were in boarding houses.

The lowest concentration of "psychiatric" clients per caseload, 8%, occurred in the northern suburban area. As well, in this area a greater percentage, 39%, lived at home with their family than lived in any other type of housing situation. In fact, more psychiatric clients lived with family in this area than in any other area of the City.

One welfare worker for the northern suburban area wrote, "The psychiatric clients on my caseload, except one, seem adequately provided for in terms of living conditions. Most reside with their parents. Homes are nicely kept and quite modest." However, another worker pointed out, "In my experience, living at home with parents quite often causes the initial improvement in the (psychiatric) patient to deteriorate. Family dynamics in most instances are deplorable and totally devastating to patients' improved mental condition."

Other general welfare assistance field workers at various offices wrote the following:

> "Many of these clients live in rooming houses where they rent one room or live as boarders. They are often exploited by the people they live with in terms of the way they are treated and spoken to, as well as exploited materially - money and personal items are frequently stolen. They have no support systems within the community, and loneliness often worsens their problems. Some need to take medication regularly but need to be reminded; since there is no one to remind them, they forget and end up in severe states of depression.
>
> "None of my present clients who seem to have psychiatric problems are receiving any care from mental health agencies. All live in rooming houses with substandard conditions.
>
> "Clients tend to live in cockroach-infested, dirty, smelly rooming houses, paying more than $170/month rent. That is more than 50% of the general welfare assistance. Little else is available at an affordable rate of rent.
>
> "Most of these people live in small, dirty rooms. In some cases nearly all their monthly assistance goes towards rent. As a result, they must often rely on the Scott Mission or other resources to get their meals."

Question #5

HOW MANY EX-PSYCHIATRIC PATIENTS ARE CURRENTLY HOMELESS OR WITHOUT ADEQUATE HOUSING?

Over the past year and a half, hostel staff have reported increasing numbers of ex-psychiatric patients seeking shelter in the hostels. There are 18 hostels in Metro Toronto that provide short-term or emergency accommodation of last resort. They have a total bed capacity of 1,740.

In order to gain a better understanding of the scale of this problem, a survey of all the hostels was undertaken. The two key questions in the survey asked "How many people known to have some history of psychiatric contact stayed in the hostels tonight? (i.e., takes medication, referred from mental health service, own statement, reliable source)" and "How many people who probably have some history of psychiatric contact stayed in the hostel tonight? (i.e., bizarre behaviour, confused, delusional, hallucinating, other)". These criteria were selected after discussions with hostel intake staff, and others in the mental health field.

The results of the survey conducted on the night of April 6th, 1982, are presented on the next page in TABLE 2.

TABLE 2

HOSTEL SURVEY - APRIL 6, 1982

HOSTEL	TOTAL NO. OF ADULTS IN HOSTEL	(A) NO. WITH PSYCH. HISTORY	(B) NO. WITH PROBABLE PSYCH. HISTORY	SUM OF (A) + (B)	SUM AS % OF TOTAL ADULTS
Family Residence	65	14	7	21	32%
Seaton House/Single Men's Hostel	454	63	22	85	
Toronto Community Hostel	9	-	3	3	33%
Interval House	8	n/a*			
Women In Transition	9	n/a*			
Women's Habitat	8	2	-	2	25%
Stop 86	24	1	1	2	8%
Streethaven	7	-	-	-	
Salvation Army	431	5	44	49	11%
Men's (Includes Rented Rooms) Hostel "X"**	120	9	2	11	9%
Anduhyaun	6	n/a*			
Stopover	63	6	3	9	14%
Woodlawn Residence (3 Emergency Beds)	3	1	1	2	67%
Nellie's Hostel	27	7	3	10	37%
Evangeline (Short Term Beds)	15	3	-	3	20%
All Saints Church	154	18	20	38	25%
Dixon Hall Shelter	57	10	3	13	23%
Good Shepherd Refuge	13	1	-	1	8%
TOTAL	1,473	140	109	249	17%

* Three hostels do not <u>normally</u> admit persons with a psychiatric history.

** One of the hostels did not wish to be identified.

Hostel residents with a known psychiatric or probable psychiatric history: 249 or 17%.

The total of 249 people with known or probable psychiatric history in the hostels on April 6, 1982, is probably a conservative estimate. Most of the hostels were not filled to capacity because, as staff explained, "there is still money around since the welfare cheques only came out at the first of the month". In addition, Streethaven and Toronto Community Hostel (with a chicken pox outbreak) reported that they typically see more ex-psychiatric patients.

It is important to recognize that the smaller the hostel, the more reliable the data. In the smaller settings more detailed information on residents is obtained and there is more contact between staff and residents. Some smaller hostels agreed to complete individual questionnaires on the target population. In these cases the greater staff familiarity with residents was readily apparent in such descriptions as "observed physically abusing (intensely hitting) herself"; "suicide attempts 1979"; and "talks continually to herself or to companions who we cannot see". When the more detailed information is examined, the number of residents with known and probable psychiatric history is 44 out of 171, or 26%. (The hostels providing detailed information were: Family Residence, Toronto Community Hostel, Women's Habitat, Stop 86, Streethaven, Woodlawn, Nellie's, Evangeline, and The Good Shepherd Refuge.)

Among the hostels a hierarchy was evident in terms of willingness to admit people with psychiatric problems. Of the 18 hostels in Metropolitan Toronto, three smaller hostels for women and children indicated that they could not handle and therefore would not normally admit people whose main problem was psychiatric in nature. Some of the women's hostels are known for their relatively tolerant admission policies, and therefore receive a disproportionate number of ex-psychiatric patients. The large single men's hostels and the overnight winter drop-in's have very open admission policies. At the bottom of the hierarchy are the Metro-operated hostels (Family Residence and Seaton House) which are required to take anyone in need of shelter.

Most of the hostels have some system for excluding people they have had trouble with in the past. Six hostels were willing to discuss their "barred lists" or "caution alerts". If a name appears on the barred list, then that person is prohibited from staying in the hostel for a time period which may vary from a week to a year. The "caution alerts" are notes attached to a person's record that warn intake staff to assess whether or not the hostel is equipped that night to handle someone known to be difficult. If there are a large number of children in the house that night, the person will generally be referred to another hostel. A staff member from Nellie's Hostel for Women commented: "for them to get on our list, they would have to be on everyone else's. We send them on to the Dundas Family Residence and they probably send them

on to All Saints (overnight drop-in). This of course just makes them crazier."

The "barred list" and "caution alert" figures are presented in TABLE 3.

TABLE 3

PERSONS ON HOSTEL "BARRED LISTS" OR "CAUTION ALERTS"

HOSTEL	NUMBER OF PERSONS ON "BARRED LIST"	ESTIMATED NUMBER WITH PSYCHIATRIC HISTORY ON LIST	NUMBER OF PERSONS ON "CAUTION ALERT" LIST	Estimated ESTIMATED NUMBER WITH PSYCHIATRIC HISTORY
A	158	69		
B	29	29		
C			192	120
D	12	5		
E	47	33	64	52
F	120	114		
TOTAL	366	250 (1)	256	172 (2)

(1) Percentage of persons with a psychiatric history on the "barred list": 68% (250).

(2) Percentage of persons with a psychiatric history on "caution alert": 67% (172).

While keeping in mind that many of the same people are on different lists, the high percentage of people on the barred lists for psychiatric reasons clearly shows the existence of a subgroup of the psychiatric population who often do not have access to even the minimal shelter offered by the hostels.

Another problem for the hostels in housing their psychiatric populations is a lack of staff training. Many hostel staff reported that they had, of necessity, learned to handle ex-psychiatric patients on the job. One of the most serious

difficulties for a short-staffed hostel is to have a resident experience a crisis while staying in the hostel. One staff member put it this way: "When there's only one or even two staff members on at night, we can't spend all our time occupied with one of the residents who is having problems. What about the rest?" Great frustration was expressed over the lack of help available in these situations. Staff complained that hospitals were reluctant to admit residents in crisis. Often the only option was to call in the police to remove the person from the premises.

Many hostel staff also expressed mistrust of the hospitals who referred ex-patients. Hostel staff felt that they were often not given enough information about the person, that referring staff were frequently evasive about the person's current problems and that, in some cases, the person was referred before they were ready. One senior staff member at a large men's hostel commented "The traffic is all one way. We get someone here who goes crazy and we can't get them back into the hospital". This hostel reports that they frequently receive people straight from a psychiatric facility with no prior referral.

In the course of this study, hostel staff mentioned four deaths that they felt were related to lack of adequate housing. Upon investigation, two of these deaths could only indirectly be linked to lack of a supportive housing environment. The third case was that of a middle-aged woman with extensive psychiatric history who could not secure any stable accommodation. As a result, she moved from hostel to hostel. The woman confided to a hostel staff member how worried she was about having no permanent housing and the prospect of having to go to yet another hostel. The following day she left the hostel and killed herself by jumping off Queen's Quay with cement tied around her ankle.

The fourth case is that of another middle-aged woman with extensive psychiatric and drug-abuse history. She stayed in the hostels after her discharge from hospital and eventually wore out her welcome. With the help of a housefinder she was placed on her own in a single apartment. Less than three weeks later, she was found dead in her room. She had been dead for at least five days, and the cause of death has yet to be determined.

No one can be certain that a supportive housing environment would have prevented these deaths and others like them, but the availability of support for a person prone to crisis might reduce the likelihood of such tragedies.

Various community agencies operate programs for the ex-psychiatric population. Five of these agencies were asked for their observations on the housing problems of their clients and the impact of these problems on the deterioration of the clients' conditions.

1. Sistering, a small drop-in centre, operates a day care program primarily for women staying in the hostels. Out of the average 22 women who drop in each day, over half, or 14, are ex-psychiatric patients. All are in need of suitable housing. A senior staff member notes that "those who really want a room go and find it. But they always come back to the hostels. They may hate the hostels but it's more homelike than a lonely little room". Generally these women were also very poor.

2. In June, 1981, WoodGreen Community Centre secured funds to hire a psychiatric aftercare worker. She has seen a total of 52 clients, 31 of whom have had multiple admissions to hospital. In a progress report on the program she paints a bleak picture of the lack of adequate housing. Twenty-seven of the 52 clients were in need of suitable accommodation. On follow-up, about a third were transient and impossible to track. Over a third of the remaining people were still waiting to get into various types of housing. The problems she identified for this delay included: the housing shortage, the cost of housing, and waiting lists for the most suitable type of housing (i.e., co-ops and supervised settings). In addition, the psychiatric aftercare worker emphasized that the ability to find housing is a major factor influencing the outcome of the entire aftercare program. Her report noted ominously that two of the most influential factors in rehospitalization were the deterioration of people stuck on waiting lists to get into community programs, and the lack of adequate housing.

3. A senior staff member at Our Place, a Yonge Street drop-in for ex-psychiatric patients, estimated that of their 400 members, 60% are currently having housing problems. The cost of accommodation is the main worry, since room and board leave many with less than $20 per month. The staff member commented further that "once a person doesn't have peaceful home surroundings, and most of these people don't, it's a safe bet that there's a link to deterioration".

4. Progress Place is a suburban social-recreational program for a nontransient population of 100 former psychiatric patients. The assistant director said that inquiries about housing are on the increase. Finances and housing were the two problems most often mentioned to staff. The staff member estimated that 28% of the centre's members have ongoing housing problems. He added that the tight housing market and the lack of available alternatives mean that many clients are staying in family situations that may be inappropriate for the client and the family. If there were options, many of these people would move out. As for alternative housing - a most desirable option in the assistant director's view - "with the waiting lists maybe a space comes up but the situation may have changed or deteriorated".

5. At Parkdale Area and Recreation Centre (PARC), a large community drop-in for the psychiatric population, staff reported that a majority of their 350 members are dissatisfied with their housing arrangements. While determining reliable numbers in this setting fell outside the scope of this survey, the following data is presented in order to give a human face to the numbers. This information is based on five one-to-one interviews with discharged psychiatric patients. No attempt at systematic survey has been made, and the problems presented are not necessarily typical of the psychiatric population as a whole. However, staff at PARC emphasized that these cases do reflect the problems experienced by many of the PARC clients.

   The first young woman interviewed was evicted from a shared house shortly after hospitalization for a suicide attempt. She turned to prostitution to support herself, as she had heard that she could not get welfare since she lacked any identification. She was beaten up more than once, raped, and finally decided she would go to one of the hostels. She recontacted her former worker and is now waiting to be admitted to co-op housing. This young woman definitely sees a link between finding adequate accommodation and making some progress with her life.

   The next person was an older woman who secured a room earlier this year, after looking for months. She had to be rehospitalized shortly after she moved in. "Three weeks later I was back to my senses and phoned the landlord. They didn't hold my room and put my stuff in three shopping bags. I went to the room as soon as I was out of the hospital but I never got my stuff." The woman then produced a crumpled piece of paper listing rooms for rent and given to her by her therapist. She had telephoned only to find that her disability benefits would not even cover the cost of a month's rent. She has discovered that most landlords do not want to rent to single women who smoke, especially if they are on social assistance.

   Her current accommodation, a tiny bachelor that is so noisy it's hard to sleep, and where she constantly fears that her few possessions will be stolen, costs her $215 per month. She receives groceries from the Scott Mission, and has stayed in most of the hostels in Metro.

A young man who was released from hospital last May said he was placed in a boarding home, after temporarily locating in a hostel. He stayed at the boarding home for two weeks, then moved to an apartment with a shared kitchen. There were quite a few alcoholics in the building, so again he moved, this time to another boarding house where he pays $280 per month for room and board. This leaves him with $76 per month. He complained at length about the quality and quantity of the food and concluded: "If I had my choice, do you think I'd be in a boarding house?"

Finally, a young couple describe their experience with the "Catch-22". It took them two months of repeated attempts, plus intervention on their behalf of the community centre and a legal clinic to convince general welfare assistance to give them the money for a rental deposit on a place it had taken months to find.

Question #6

DOES THE LEVEL OF INCOME AVAILABLE TO EX-PSYCHIATRIC PATIENTS AFFECT THEIR ABILITY TO FIND SUITABLE HOUSING?

Well over half of the patients discharged at the two psychiatric facilities examined during the survey time period relied on general welfare assistance or family benefits as their source of income. At the Queen Street Mental Health Centre, 50% (36) depended on general welfare assistance and 17% (12) were in receipt of family benefits or disability allowance. 3% (2) were reported to have no source of income.

At the Clarke Institute, 51% (15) received general welfare assistance or family benefits.

Since the maximum allowable benefit for a single, unemployable person on general welfare assistance is $288 per month, and the maximum allowance for a single, disabled person on family benefits is $364 per month, it is fair to say that half the psychiatric patients discharged during our survey had an income below the poverty level (5).

An attempt was made to obtain statistics for the number of recipients on general welfare assistance and on family benefits for reason of psychiatric impairment. However, the Metro Toronto Department of Community Services advised that clients classified as "medically unemployable" were not further separated into

unemployable for psychiatric reasons as distinguished from physical reasons, and therefore they had no records available on this particular problem.

Similarly, the Ontario Ministry of Community and Social Services, which is responsible for the administration of the Family Benefits Act, advised that they could not provide figures specifically for those recipients classified as "permanently unemployable" or "disabled" for reasons of psychiatric impairment as separate from physical impairment.

In the course of the research, two main problem areas regarding welfare for ex-psychiatric patients were revealed, one concerning general welfare assistance, and one concerning family benefits.

With regard to general welfare assistance, both psychiatric facility discharge planners and housing placement workers spoke about a "Catch-22". They referred to the fact that a needy person cannot get general welfare assistance without an address, but cannot get an address without funds from general welfare assistance. An effort has been made on the part of the Department of Community Services to alleviate this situation by accepting a letter or phone call at the local general welfare assistance office from a hospital staff member on behalf of a discharged psychiatric patient. Then some amount, usually $50, is issued to the ex-patient to find accommodation, and he notifies the local office to arrange a home visit by the welfare worker. Many situations were reported by general welfare assistance workers, however, of these ex-psychiatric patients not being able "to get it together enough" to find an address with their limited resources and capabilities.

It appeared that some local general welfare assistance offices were more likely to grant this money to find an address than others; it also appeared that some hospital discharge planners had more of an appreciation than others of the requirement to contact the general welfare assistance office by phone or letter to assist in the determination of the ex-patient's eligibility.

With regard to family benefits, the main problem area for ex-psychiatric patients was their confusion between being classified as "permanently unemployable" or "disabled". Their main concern was the fact that a "permanently unemployable" person receives $318 per month in assistance, while a "disabled" person receives $364 per month. Family benefits administrators advised that the classification decision was "solely a medical ruling", based on the information on the Medical Report Pertaining To Impairment (Form 4). This, and any other medical documentation submitted, determined whether an applicant was "permanently unemployable" or "disabled". (For the definitions of each of these terms in the family benefits regulations, see APPENDIX IV). A lesser problem for the ex-patients concerning family benefits was stated to be

the length of time it takes to be granted benefits after initially making application - up to 3 months. (Most applications for the higher benefits under family benefits are made by persons in receipt of general welfare assistance at the time.) In explaining this delay, family benefits administrators advised that frequently the Medical Report (Form 4) does not contain sufficient information for a medical decision by the Medical Advisory Board to be made. Decisions are then delayed while additional documentation is requested. It is noted that the most common reason (69%) for refusal of family benefits at the Social Assistance Review Board appeals is "Not Considered Permanently Unemployable" - a decision based on medical evidence.

Ex-psychiatric patients living on welfare have a severely limited range of housing available to them. Apartments are seen as out of the question due to the necessity to deposit the first and last month's rent, an amount most of these people simply do not possess. The cheapest rented rooms within the City charge $35-$40 per week, more than half the amount issued by general welfare assistance for the period. Boarding houses, rarely offering more than food and lodging, cost from $230 to $270 per month. Even the lower rate, $230, is 89% of the maximum general welfare assistance monthly allowance.

Co-operative residences providing weekly supervision/support - of which Houselink Community Homes is an example - rent from $125 to $150 per month. Modified cooperatives, providing daily supervision/support, such as Palmerston House, charge $200 per month room and board. The Salvation Army Dufferin Residence, extending 24-hour supervision/support in part of its establishment, has a sliding scale of charges based on income. However, in this facility, because of its source of funding, residents are not eligible to receive general welfare assistance.

The two large community centres surveyed, Parkdale Activity and Recreation Centre and WoodGreen, report that welfare advocacy has become an important part of their service. Both community centres report that intervention in the form of phone calls or letters with official letterhead is often necessary to assist ex-psychiatric patients in getting the emergency assistance needed to make a rent deposit.

Most of the ex-patients surveyed at the Community Centre reported that a lack of funds was at the root of their problems finding adequate, affordable housing.

Three of the alternative housing operators surveyed reported long delays for their clients seeking to transfer from general welfare assistance to family benefits. One operator estimated that it took 3-9 months to make the change. This problem is particularly serious for two of the facilities where residents are ineligible

for general welfare assistance. The other operators are not aware of problems in this area.

Question #7

HOW HEAVY IS THE DEMAND FOR THE AVAILABLE SUPPORTIVE HOUSING?

All ten alternative community housing operations report increased demand for the 133 beds they have available. Dufferin Residence, the only facility offering 24-hour support, notes that referrals in the first three months of 1982 are up to 32, from 12 for the same period in 1981. Inquiries other than referrals are also up to 49 from 27 in the first three months of 1981. Houselink, one of the larger operators of cooperative housing, with 50 beds and an emphasis on residents supporting one another, received approximately 250 inquiries (excluding referrals) in the first three months of this year. There were 37 referrals in the same period, down from 43 a year ago. The other operators report a range of inquiries from one per week to six per day. But all confirm an increase. Regeneration House, with 13 beds and a reputation extending outside Toronto for admitting younger adults, draws 90-100 referrals per year.

The waiting lists also offer evidence of the heavy demand for supportive housing. Three operators say they do not keep waiting lists as they have no difficulty filling a space should one become available. For Houselink, 38 people are waiting to get in. All 38 people are considered suitable for the accommodation offered.

The major indicator of increased demand for Houselink is the fact that only a year ago the names of prospective residents stayed on the waiting list an average of five to six weeks, while now the wait is two to three months. The total number of people seeking accommodation in those community housing operations which keep waiting lists is 59.

One of the reasons the waiting period has increased is that residents appear to be staying longer at the four alternative houses that permit an indefinite length of stay. Given the low rents (from a low of $190 to $250 per month for room and board) this is not surprising. According to one staff member "as a result of harder economic times, people are staying longer and thinking twice about moving out. Since people aren't moving out as fast, others are on the waiting list longer".

Question #8

DO HOUSING PROBLEMS CONTRIBUTE TO READMISSION TO A PSYCHIATRIC FACILITY?

This was an extremely difficult area in which to obtain figures, since records describing this problem are not routinely kept by hospitals. Even records of patient admissions noting "no fixed address" are suspect since, as one nurse explained, some patients seeking readmission say they have no place to live when they in fact do, hoping to strengthen their case for admission. Conversely, other patients offer a relative's or friend's address where they are not actually residing, in order to satisfy the admitting staff's request for an address.

Interviews at the Queen Street Mental Health Centre indicated that, following the usual procedure, a medical assessment would be made of the ex-patient presenting for admission, and a decision would be made as to whether or not to admit him as an in-patient. It was felt that simply being without accommodation would not be sufficient reason for admission. In such a case, a referral would be made to a hostel or boarding home.

At the Clarke Institute of Psychiatry, staff in the Emergency Department advised that in a 24-hour period they might see from 2 to 20 persons seeking admission. The comment was made that it was "too difficult to say how many are housing problems, but it is a problem". Staff stated that many of the people seen in the Emergency Department were former patients of the Institute, often chronic schizophrenics who had gotten into a fight at their home and had to leave. Being homeless and disliking the hostel accommodation, ex-patients would seek readmission. It was "hard to say" how many of these homeless individuals would gain admission.

At the northwestern suburban hospital, "drop-ins" seeking admission because they were without housing were not common. If a former patient of the hospital were seeking readmission because "where they're staying now (often with family) is falling apart", it was felt admission would be granted. The comment was made that people from the area this hospital serves "would not even consider" going to a hostel.

At the east end hospital, an estimate of the number of people appearing for admission due to lack of housing could not be made. One staff member did say, however, that former patients who had to live in a "destructive housing environment" were often readmitted.

At the downtown hospital, a therapist gave an example of a case where housing conditions contributed directly to readmission. One former psychiatric patient living in a "chaotic rooming house full of alcoholics" became so stressed that she was readmitted to

hospital, and her housing situation was considered to have "had a direct relation to her admission".

As well, the operators of the community programs repeatedly stressed the relationship between difficulties in finding adequate housing and readmission to hospital.

General welfare assistance workers also mentioned the correlation between inadequate housing and the deterioration in ex-psychiatric patients' conditions.

As pointed out in the Psychiatric Aftercare in Metropolitan Toronto study, the environment of those ex-patients in extremely inadequate housing would be harmful to anyone's mental health, and indeed, the fact of dissatisfaction with living conditions has been demonstrated in the literature to be a strong predictor of readmission (6).

CONCLUSIONS AND RECOMMENDATIONS

Supportive Housing

Virtually every dimension of the housing situation examined affirmed the need for increased supportive housing.

A significant portion (20%-31%) of psychiatric patients ready to leave hospital is not discharged for want of appropriate accommodation. This is not only a waste of a costly health service, but, more importantly, is detrimental to the well-being of the patients. The study shows that a majority of people (53% - 62%) reentering the community were assessed by professionals as being in need of a supportive housing environment. Specialists in the field of locating housing for ex-psychiatric patients consistently report difficulty in making housing placements. In the Parkdale area well over half (58%) of the patients who receive welfare benefits live in unsupported boarding homes. The one-night survey of the hostel system found 249 people with a psychiatric background staying in the hostels, and uncovered the existence of a subgroup of this population who are often barred from even this minimal shelter. The ten existing supportive housing operations generally report increased inquiries, more referrals and longer waiting lists.

Therefore, it is recommended that the Ministry of Health immediately provide funding to increase the number of supportive housing beds in the Toronto area. This should include a range from high-support 24-hour facilities to models of minimal supervision. A major initiative will be required to create sufficient supportive housing to meet the demonstrated need.

Coordination of Support

Many patients lose contact with institutions and agencies following discharge from a psychiatric facility. Welfare workers note that many of their clients with psychiatric problems are not connecting effectively with mental health services in the community. The number of different programs under a variety of administrative and jurisdictional structures can be a frustrating maze to the discharged psychiatric patient, who is often viewed by the system as an exceptionally difficult case.

Therefore, it is recommended that the Ministry of Health take the lead in establishing a mechanism for coordination of support services to ex-psychiatric patients in the community.

Income Maintenance

a) Ex-psychiatric patients are restricted in their ability to find suitable housing by the low level of their incomes, and the limited range of housing available. For those whose only income is general welfare assistance ($288 per month) or family benefits ($364 per month), the choice is severely limited.

   Therefore, it is recommended that the Metropolitan Toronto Department of Community Services and the Ontario Ministry of Community and Social Services increase the allowance rates for discharged psychiatric patients, and that the shelter supplement be mandatory for this group.

b) One of the problem areas for ex-psychiatric patients seeking to obtain general welfare assistance is the fact that a needy person can't receive this benefit without having a residence, but can't get a residence without funds from general welfare assistance - the so-called "Catch 22". Although some organizations, such as WoodGreen Community Centre, have an arrangement with the general welfare assistance office in their area, many others do not.

   Therefore, it is recommended that the Metropolitan Toronto Community Services Department establish arrangements with community programs and institutions to remove this obstacle.

c) Another problem area for ex-psychiatric patients seeking welfare assistance involves their difficulty in obtaining the "disabled" allowance under The Family Benefits Act. Delays exist in obtaining this allowance which is $56 higher than the rate for a "permanently unemployable" person receiving family benefits, and $106 higher than a "medically unemployable" person receiving general welfare assistance. Much of this difficulty and delay is a result of insufficient information

being submitted concerning the applicant's psychiatric disability. This is attributed to the inadequacy of the "Medical Report" form currently in use, as it is more suitable for describing physical impairment than psychiatric impairment.

Therefore, it is recommended that the Ministry of Community and Social Services work with persons familiar with the mental health system in the design and implementation of a medical report form pertaining specifically to psychiatric impairment.

Hostels

Results of the hostel survey show a significant number of ex-psychiatric patients among the hostel clientele (249). Hostel staff report that they receive no training in dealing with this group, one of the most difficult in the hostels. The hostels badly need substantial support in their efforts to serve the ex-psychiatric population, as it is likely that for the short term this group will continue to seek shelter in the hostels.

Therefore, it is recommended that the Ministries of Health and Community and Social Services, and Metro Toronto fund enrichment services to complement the hostel programs.

Crisis Intervention

Many hostel staff report little help available for a hostel resident experiencing a crisis. Often, the only available option is to call in the police to remove the person from the premises. People with a psychiatric history constitute 68% of those on the hostels' 'barred lists', and 67% of those on 'caution alerts', reflecting the difficulties hostel staff have in coping with these people.

Therefore, it is recommended that the Ministry of Health accept and implement the recommendation made by the Supportive Housing Coalition in the "Community Housing for Consumers of Mental Health Services in Metropolitan Toronto" Report, "That a 24-hour crisis team be established immediately to respond to mental health crisis needs of residents of boarding and lodging homes and hostels; that a community crisis facility (minimum of 5 beds) be established in 1982 for those who cannot be handled in a residential setting."

Data Collection

There is a significant lack of readily available data with regard to persons living in the community with current or past

psychiatric problems. Such information is essential for the planning of community-based facilities and programs.

a) Therefore, it is recommended that the Ministry of Community and Social Services develop a mechanism which can provide data on the number of family benefits recipients classified as "permanently unemployable" and "disabled" for reasons of psychiatric impairment, as opposed to physical impairment.

b) It is also recommended that the Metro Toronto Department of Community Services develop a method for ascertaining the number of general welfare assistance recipients classified as "medically unemployable" for psychiatric reasons rather than physical reasons.

c) It is also recommended that the Ministry of Health establish procedures in psychiatric facilities to ensure that information is maintained, monitored and made available on:

   i) Patients having no housing on admission to hospital;

   ii) Patients whose discharge from hospital is delayed due to lack of appropriate housing placements; and

   iii) The success of housing placements in the community on discharge.

Advocacy Role of the Department of Public Health

It is recommended that the Toronto Department of Public Health work with all appropriate community groups and agencies to seek the implementation of the above recommendations.

SUMMARY OF RECOMMENDATIONS

1. That the Ministry of Health immediately provide funding to increase the number of supportive housing beds in the Toronto area. This should include a range from high-support 24-hour facilities to models of minimal supervision. A major initiative will be required to create sufficient supportive housing to meet the demonstrated need.

2. That the Ministry of Health take the lead in establishing a mechanism for coordination of support services to ex-psychiatric patients in the community.

3. That the Metropolitan Toronto Community Services Department and the Ontario Ministry of Community and Social Services increase the allowance rates for discharged psychiatric patients, and that the shelter supplement be mandatory for this group.

4. That the Metropolitan Toronto Community Services Department establish arrangements with community programs and institutions to remove the residency obstacle to receive general welfare assistance.

5. That the Ministry of Community and Social Services work with persons familiar with the mental health system in the design and implementation of a medical report form pertaining specifically to psychiatric impairment.

6. That the Ministries of Health and Community and Social Services, and Metropolitan Toronto fund enrichment services to complement the hostel programs.

7. That the Ministry of Health accept and implement the recommendation made by the Supportive Housing Coalition in the "Community Housing for Consumers of Mental Health Services in Metropolitan Toronto" report, "That a 24-hour crisis team be established immediately to respond to mental health crisis needs of residents of boarding and lodging homes and hostels; that a community crisis facility (minimum of 5 beds) be established in 1982 for those who cannot be handled in a residential setting."

8. That the Ministry of Community and Social Services develop a mechanism which can provide data on the number of family benefits recipients classified as "permanently unemployable" and "disabled" for reasons of psychiatric impairment, as opposed to physical impairment.

9. That the Metropolitan Toronto Community Services Department develop a method for ascertaining the number of general welfare assistance recipients classified as medically unemployable" for psychiatric reasons rather than physical reasons.

10. That the Ministry of Health establish procedures in psychiatric facilities to ensure that information is maintained, monitored and made available on:

    i) Patients having no housing on admission to hospital;

    ii) Patients whose discharge from hospital is delayed due to lack of appropriate housing placements; and

iii) The success of housing placements in the community on discharge.

11. That the City of Toronto, Department of Public Health work with all appropriate community groups and agencies to seek the implementation of the above recommendations.

APPENDIX I

Please return to: Ms. Beverly Abosh, 8th Floor
by Thursday, April 8, 1982

The City of Toronto, Department of Public Health/Supportive Housing Coalition Join

PATIENT DISCHARGE QUESTIONNAIRE

To be completed for each patient considered for discharge during the period Friday, April 2 - Thursday, April 8, 1982 (inclusive)

One questionnaire per patient Unit _____

1. Patient's sex: Male _____ Female _____
   age: _____
   current income source:

2. Where will this patient live upon discharge? (check one)

   Rented Room ___ Group Home ___ Residence _____ (Specify)

   Room & Board ___ Approved Home ___
   Rented Apartment ___ Home for Special Care ___
   With Family ___ Other _____ (Specify)

3. Is this patient returning to his previous home address? (i.e., his accommodation prior to admission)

   Yes ___
   No ___ If "NO", why not? _____

4. Has the patient required your assistance in arranging his housing in the community? Yes _____ No _____

5. Has the patient's discharge been delayed in an attempt to find housing accommodation in the community? Yes _____ No _____

6. On discharge, which <u>one</u> of the following would the patient require if it were available:

24-hour supervision/support (live-in staff) _____	Weekly supervision/support (staff on-call for support and crisis intervention) _____
Daily supervision/support (daily full-time staff) _____	Patient is able to live independently _____

5. Have you used the Queen Street Mental Health Centre Assessment and Referral Unit?

6. Any comments regarding the housing situation for psychiatric patients would be appreciated. (Please use the reverse, if required).

APPENDIX II

Please return to: Ms. Beverly Abosh, 8th Floor
by Thursday, April 8, 1982

The City of Toronto, Department of Public Health/Supportive Housing Coalition Joint Project is endeavouring to clarify the numbers and needs of psychiatric and ex-psychiatric patients living in the community. The focus of the project is housing. The project researchers are gathering information from Queen Street Mental Health Centre, community hostels, community programs, psychiatric units of general hospitals, family benefits, and general welfare assistance offices.

The social workers at the Clarke Institute represent one important group whose input is also being sought. Your cooperation would be appreciated.

We are requesting that:

1. For each patient being considered for discharge during the period Friday, April 2 to Thursday, April 8 (inclusive, one brief questionnaire be completed;

2. Each social worker involved in discharge planning share their experience by completing the following general survey.

General Survey

Unit _____

1. Do most patients being discharged: (check one)

   Have the ability to arrange housing themselves? _____
   Have a social worker arrange housing for them? _____

2. What is the major problem you, as a social worker, face in obtaining housing for a patient being discharged?

3. Is there any group for which it is more difficult than others to find a housing placement?

4. When a patient is medically ready for discharge, but has no source of income, what is the usual procedure followed?

APPENDIX III

he Toronto Department of Public Health / Supportive Housing Coalition Joint Study is endeavouring to clarify the number and needs of psychiatric and
x-psychiatric patients living in the community. The Community Service Centres represent one important group whose in-put is being sought. Your co-
peration in completing the following questionnaire is appreciated.

hich office do you work in? _____ Total number of clients on your Regular Caseload _____

WE ARE SEEKING DATA ONLY FOR THOSE CLIENTS WHO YOU KNOW OR THINK PROBABLY HAVE CURRENT OR PAST MENTAL/PSYCHIATRIC PROBLEMS.

lease complete one line across on the questionnaire for each of these clients.

#	SEX (M/F)	AGE	DATE PLACED ON PERMANENT CASELOAD (MONTH & YEAR)	PRESENT ACCOMMODATION							
				RENTED ROOM (✓)	ROOM & BOARD (✓)	RENTED APARTMENT (✓)	APPROVED HOME (✓)	HOME FOR SPECIAL CARE (✓)	GROUP HOME (✓)	RESIDENCE: (SPECIFY)	OTHER: (SPECIFY)
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
11.											
12.											
13.											
14.											
15.											
16.											
17.											
18.											

lease indicate any comments or suggestions you have regarding the unmet housing needs of these clients on the Regular Caseload, or similar clients
ou have seen on Temporary assistance: (Use reverse side)

APPENDIX IV

INDIVIDUAL SHEET

Person's name or code name: _____
(for hostel use only)

1. S E X: Male _____ Female _____

2. A G E: (a) 16 - 24 _____
(b) 25 - 44 _____
(c) 45 - 65 _____
(d) 65+ _____

3. Source of Income:

(a) Welfare (g.w.a.) _____
(b) Family benefits (f.b.a.) _____
(c) Other income _____
(d) No apparent income _____

4. Does this person have a known history of psychiatric care?
(Check all that apply)

(a) Takes medication _____
(b) Referred by mental health service _____
(c) Person's own statement _____
(d) Another reliable source (specify) _____

5. In your opinion is it probable that this person has a history of psychiatric problems? (Check all that apply)

(a) Bizarre behaviour _____
(b) Confused, delusional, hallucinating _____
(c) Other (specify) _____

COMMENTS: _____
_____
_____
_____
_____

APPENDIX V

Regulation Made Under The Family Benefits Act, 1966

1. (4) For the purposes of the Act and this Regulation,

(b) "disabled person" means a person who has a major physical or mental impairment that is likely to continue for a prolonged period of time and who, as a result thereof, is severely limited in activities pertaining to normal living, as verified by objective medical findings accepted by the medical advisory board;

(c) "permanently unemployable person" means a person who is unable to engage in remunerative employment for a prolonged period of time as verified by objective medical findings accepted by the medical advisory board.

Local Board of Health May 31, 1982

SUMMARY SHEET

1. What is the hostel's total capacity? _____

2. How many people are staying the night? _____

3. Tonight there are:

Total Number of Males: _____	Total Number of Females _____
16 - 24 _____	16 - 24 _____
25 - 44 _____	25 - 44 _____
45 - 65 _____	45 - 65 _____
65+ _____	65 + _____

Total Number of Children: _____

4. How many people known to have history of psychiatric contact stayed in the hostel tonight? (i.e., takes medication, referred from mental health service, own statement, reliable source) _____

5. How many people who probably have some history of psychiatric problems stayed in the hostel tonight? (i.e., bizarre behaviour, confused, delusional, hallucinating, other) _____

6. How many of the hostel residents with psychiatric history have been here often enough to be recognized by staff? _____

7. How many people with some known or probable psychiatric history were referred elsewhere? _____

8. Where were they referred? _____

9. Would you describe tonight as a typical Tuesday night? _____

10. Comments: _____

REFERENCES

1. Community Resources Consultants of Toronto and Clarke Institute of Psychiatry, Psychiatric Aftercare in Metropolitan Toronto, Toronto, 1981.

2. Supportive Housing Coalition, Community Housing for Consumers of Mental Health Services in Metropolitan Toronto. Toronto, 1981.

3. Metropolitan Toronto Community Services Department, Hostel Policy and Program Review, Toronto, November, 1981.

4. Supportive Housing Coalition, Community Housing for Consumers of Mental Health Services in Metropolitan Toronto, p. 1, Toronto, 1981.

5. See Ontario Welfare Council and the Social Planning Council of Metropolitan Toronto, ...And The Poor Get Poorer, Toronto, 1981. This report shows that the income levels provided by general welfare assistance and by family benefits are below the poverty line defined by Statistics Canada.

6. Community Resources Consultants of Toronto and Clarke Institute of Psychiatry, Psychiatric Aftercare in Metropolitan Toronto, p. 61, Toronto, 1981.

POOR

QUALITY

ORIGINAL